

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN0504</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARYVILLE HEALTHCARE AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1012 JAMESTOWN WAY</b> <b>MARYVILLE, TN 37803</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments  During investigation of C/O #27970, conducted August 3, 2011, at Maryville Healthcare and Rehab, no deficiencies were cited under Chapter 1200-8-6, Requirements for Nursing Homes.	N 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

SZ1P11

If continuation sheet 1 of 1